Department of Employee Trust Funds 801 W. Badger Road P.O. Box 7931 Madison, Wisconsin 53707-7931

## GROUP HEALTH INSURANCE MONTHLY DELETIONS REPORT

Enrollment Indicator

Wis. Stats. § 40.06, 40.51 (7)

Employer Name		Employer Number <b>69-036-</b>		Agency #	Group/Carrier #		Deduction Month		Coverage Month		
Enrollment Type/Code	Code	EMPLOYEE			(To)			Contract Type		PREMIUM ADJUSTMENT PREVIOUS MONTH(S)	
	Employee Type/Code	Name (Last, First, Middle I.)	Social Security No.	ty No. Birthdate	Carrier Suffix	Event Date	Effective Date	Single	Family	Month(s)	Amount
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	-	TOTAL DECREASE IN CONTI	PACTS	/Doot to !	ing 2 of the Mar	othly Covers	go Donorth				
		TOTAL DEGREASE IN CONTI	MOIS	(Post to L	ine 3 of the Mor	Turily Covera	уе кероп)		<u> </u>		